

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/09/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155361	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  02/07/2011
NAME OF PROVIDER OR SUPPLIER  AMBER MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 E ILLINOIS ST PETERSBURG, IN 47567	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Dates: 02/07/11</p> <p>Facility Number: 000252 Provider Number: 155361 AIM Number: 100267780</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Amber Manor Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and several resident sleeping rooms. The facility has a capacity of 64 and had a census of 60 at the time of this survey.</p> <p>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 02/08/11</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>	K 000	<p>The submission of this plan of correction does not indicate an admission by Amber Manor Care Center that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of Amber Manor Care Center. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner.</p> <p>The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).</p> <p>To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p>	

**APPROVED**

3/1/11 DB

**RECEIVED**

FEB 24 2011

LONG TERM CARE DIVISION  
INDIANA STATE DEPARTMENT OF HEALTH

**ENTERED FEB 25 2011**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Nicole Griffith*

*Executive Director*

*2/23/11*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 7 exits was maintained to provide safe access to the public way in accordance with LSC Section 7.1 to allow up to 29 residents in the west hall safe access to the exit during an evacuation. LSC Section 7.1.6.3 requires walking surfaces shall be nominally level. The slope of a walking surface in the direction of travel shall not exceed 1 in 20 unless the ramp requirements of 7.2.5 are met. The slope perpendicular to the direction of travel shall not exceed 1 in 48. 7.1.6.4 requires walking surfaces shall be slip resistant under foreseeable conditions. The walking surface of each element in the means of egress shall be uniformly slip resistant along the natural path of travel. This deficient practice could affect up to 29 residents, as well as staff and visitors in the west hall during an evacuation.</p> <p>Findings include:</p> <p>Based on observation on 02/07/11 at 11:05 a.m. during a tour of the facility with the Maintenance Supervisor, the southwest exit discharged onto an eleven foot by seven foot wood deck type sidewalk which was connected to a concrete sidewalk which connected to a parking lot. The wooden sidewalk was uneven in places, had</p>	K 038	<p><b>K038</b></p> <p>There were no residents that suffered ill effects from K038.</p> <p>All resident have the potential to be affected by the alleged deficient practice and through corrective action the facility will ensure replacement of the wood deck type sidewalk.</p> <p><b>Completion Date 3/09/11</b></p> <p>Systemic change will be facility to ensure replacement of the wood deck type sidewalk to be in accordance with LSC Section 7.1 and LSC Section 7.1.6.3 and 7.1.6.4.</p> <p><b>Completion Date 3/09/11</b></p> <p>Plant Operations Director or designee will monitor the completion of the sidewalk replacement and report results to the QA for 12 months for further suggestions and recommendations.</p> <p><b>Completion Date 3/09/11</b></p>	

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K 038	Continued From page 2 loose slats, was slippery, had loose nails, and had several gaps between boards large enough for a wheel chair wheel to become stuck in the event of an evacuation. This was acknowledged by the Maintenance Supervisor at the time of observation.	K 038			
K 050 SS=C	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 4 of 4 quarters during 1 of 3 employee shifts. This deficient practice could affect all residents in the facility.  Findings include:  Based on review of the facility's fire drills in the Trilogy Plant Operations Manual on 02/07/11 at 10:30 a.m. with the Maintenance Supervisor present, all 4 first shift fire drills performed since January of 2010 were held between 9:30 a.m. and 10:16 a.m. During an interview at the time of record review, the Maintenance Supervisor	K 050	<b>K050</b>  There were no residents that suffered ill effects from K050  All resident have the potential to be affected by the alleged deficient practice and through corrective action the facility will ensure fire drills are held at various times under varying conditions, at least quarterly on each shift. <b>Completion Date 3/09/11</b>  Executive Director to in-service Plant Operations Director on variance of times to ensure compliance that fire drills are held at least quarterly on each shift and at varied times on each shift. Systemic change will be drills will follow a prescheduled sequence calendar which includes varying times on each shift. Executive Director will sign off on all fire drills to monitor for proper variance of times on each shift. <b>Completion Date 3/09/11</b>		

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K 050	Continued From page 3 acknowledged the times of the first shift fire drills.	K 050	Executive Director or designee will monitor completion of fire drills occurring at varying times on each shift at least quarterly. Plant Operations Director will report all finding to monthly QA for 3 three months and quarterly thereafter. <b>Completion Date 3/03/11</b>	
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 2 fire alarm control panels, located in an area not continuously occupied, was provided with automatic smoke detection to ensure notification of a fire at that location before it is incapacitated by fire. LSC 9.6.2.10 refers to	K 051	<b>K051</b>  There were no residents that suffered ill effects from K051  All resident have the potential to be affected by the alleged deficient practice and through corrective action the campus will add a hard wired smoke detection system inside the maintenance room to be in agreement with NFPA 72. <b>Completion Date 3/09/11</b>	

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K 051	Continued From page 4 NFPA 72, the National Fire Alarm Code. NFPA 72 at 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in that location. This deficient practice could affect all residents, staff, and visitors in the facility.  Findings include:  Based on observation on 02/07/11 at 10:00 a.m. during a tour of the facility with the Maintenance Supervisor, the fire alarm control panel communication system was located in the Maintenance Office which was not electrically supervised by a smoke detector. This was acknowledged by the Maintenance Supervisor at the time of observation, furthermore, the Maintenance Supervisor indicated the Maintenance Office was not continuously occupied.	K 051	Systemic changes are the campus will add a hard wired smoke detection system to the maintenance office to ensure fire safety for all residents, staff, and visitors in the facility. <b>Completion Date 3/09/11</b>  Plant Operations Director or designee will monitor the completion of the smoke detector and report results and proper function to the Safety Committee X 12 months for further suggestions and recommendations. <b>Completion Date 3/09/11</b>		
K 062 SS=F	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on record review, observation, and interview; the facility failed to ensure 1 of 1 automatic sprinkler systems was maintained in reliable operating condition. LSC 4.6.12.1	K 062	K062  There were no residents that suffered ill effects from K062.  All residents have the potential to be affected by the alleged deficient practice and through corrective action the facility will ensure installation of the underground shut off valve and replacement of the incoming pipe to be in compliance with NFPA 25		

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K 062	<p>Continued From page 5</p> <p>requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-11.1 requires maintenance shall be performed to keep the sprinkler system equipment operable or to make repairs. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's quarterly sprinkler system inspection reports in the Trilogy Plant Operations Manual on 02/07/11 at 9:30 a.m. with the Maintenance Supervisor present, the facility's dry sprinkler system inspection and testing report dated 09/09/10 stated "Severe rust on incoming pipe with no shut off valve at city side. Highly recommend replacing pipe and installing underground shut off valve", furthermore, the 12/10/10 report stated: "Severe rust on incoming 6 inch pipe on city side. No shut off valve close. Highly recommend installing a shut off valve and replacing pipe before failure." Based on observation of the sprinkler riser at 9:45 a.m. with the Maintenance Supervisor, the incoming pipe to the sprinkler riser was extremely rusty and appeared to be leaking onto the concrete floor. During an interview at the time of record review, the Maintenance Supervisor indicated the regional maintenance person for the facility was aware of the situation and was working to correct the problem, furthermore, at the time of observation, the Maintenance Supervisor acknowledged the rusty incoming pipe below the</p>	K 062	<p>Systemic change will be facility to ensure installation of the underground shut off valve and replacement of the incoming pipe.</p> <p>Plant Operations Director or designee will monitor the completion of the sidewalk replacement and report results to the QA for 12 months for further suggestions and recommendations.</p> <p>Facility has submitted request for a temporary waiver for a 30 day extension for project completion. Contractors have been selected for project and are scheduled to begin March 9, 2011 with an anticipated completion date of April 9, 2011.</p>	

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K 062	Continued From page 6 sprinkler riser.	K 062			
K 144 SS=F	3-1.19(b) NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants in the facility.	K 144	<b>K144</b>  Residents did not suffer any ill effects from this finding.  All residents have the potential to be affected be the alleged deficient practice and through corrective action facility will add a remote emergency shut off switch. <b>Completion Date 3/09/11</b>  Systemic changes are the campus will add a remote emergency shut off switch located in the maintenance office for ease of access to be in accordance with NFPA 110 and NFPA 37. Staff have been educated on location of emergency shut off switch. <b>Completion Date 3/09/11</b>  Plant Operations Director or designee will monitor the completion of project and documentation of proper function of remote generator turn off report results to QA Safety Committee X 12 months for further suggestions and recommendations.  <b>Completion Date 3/09/11</b>		

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K 144	Continued From page 7 Findings include:  Based on observation of generator equipment on 02/07/11 at 11:45 a.m. during a tour of the facility with the Maintenance Supervisor, no evidence of a remote shut off device was found for the generator, furthermore, during observation of the generator it was indicated by the Maintenance Supervisor the generator was powered with more than 100 horsepower and had been installed around 2007. Finally, based on interview at the time of observation, the Maintenance Supervisor indicated there was no remote shut off device for the generator.  3.1-19(b)	K 144		